Application Form for Fellowship in Phacoemulsification and Refractive Surgery / Vitreo-Retinal Surgery.

Name: _____

Father /Husband's Name: _____

Date of Birth _____ Sex_____ Marital Status _____

Citizen of_____

Postal Address

_____

_____

_____

_____

Permanent Address

_____

_____

_____

_____

Telephone Number with Code _____

Mobile Number _____

Email Address _____

Languages known: Tick relevant column

Laguage	Speak	Read	Write
English			
Kannada			
Hindi			
Tulu			

Medical Qualification

Basic medical degree:

Examination passed:					
Institution:					
Year of passing:					
Marks obtained in M.B.B.S: (attach a copy of the marks sheet)					
Sl. No	Subject	Max. Marks	Marks Obtained	%	No. of attempts
1	Anatomy				
2	Physiology				
3	Pharmacology				
4	Pathology & Microbiology				
5	Forensine Medicine				
6	Eye				
7	Social & Preventive				
8	Obstetrics & Gynaecology				
9	Medicine				
10	Surgery				
11	ENT				
	Total				

Ophthalmology Residency:

Qualification	Year Of Joining	Year Of Passing	University
MBBS			
DO			
MS			
Any Other			
Brief Note on Thesis Work:			

Medical Qualification

Work experience

No.	Organization	From	To	Designation
List of Publications:				
Academic Honors:				
Membership in Scientific Societies:				
Please state why this fellowship is desired & give the subject of any special interest or study that you might be interested in doing at Prasad Netralaya Super Specialty Eye Hospital if the Fellowship is granted:				
What are your ultimate future plans if you are granted the Fellowship at Prasad Netralaya Super Specialty Eye Hospital?				
Date available to begin Fellowship:				

Surgical Knowledge	No of Surgeries done with assistance	No of Surgeries done independently
ECCE		
SICS		
Phaco		

Are you routinely using operating microscope for surgeries Yes No

Type of cataract Surgery doing at present

ECCE Manual SICS Phacoemulsification

Number of cataract surgeries performed

ECCE_____ Manual SICS_____ Phacoemulsification_____

Have you used / made sclera tunnel incisions

Yes No

Approximate No. of Scleral Tunnel incision performed

<10 10-25 25-50 50-100 >100

Have you perfomed Capsulorhexis

Yes No

No. of Capsulorhexis performed

<10 10-25 25-50 50-100 >100

Declaration

I hereby declare that all the information given in this form is true and accurate.

Date:

Place: Signature

Kindly attach your c v along with application

Office Use:

Selected Not selected

Period: To:

Remarks:

Signature: